



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

VISTA HOSPITAL OF DALLAS  
4301 VISTA ROAD  
PASADENA TEXAS 77504

#### **Respondent Name**

INSURANCE CO OF THE STATE OF PA

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-08-0067-01

#### **MFDR Date Received**

AUGUST 31, 2007

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary Dated August 27, 2007:** "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges." "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below \$40,000, after the Carrier audits the bill pursuant to the applicable rules." "In this instance, the audited charges that remained in dispute after the last bill review by the insurance Carrier **\$129,825.71**...The prior amounts paid by the Carrier were **\$19,146.00**. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation reimbursement amount of **\$78,223.28**, plus any and all interest applicable."

**Requestor's Supplemental Position Summary Dated October 28, 2011:** "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment...The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons...The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons..."

**Amount in Dispute:** \$78,223.28

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary Dated September 21, 2007:** "The Requestor asserts it is entitled to reimbursement in the amount of \$97,369.28, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement..."

**Responses Submitted by:** Flahive, Ogden & Latson, 505 West 12<sup>th</sup> Street, Austin, Texas 78701

### **SUMMARY OF FINDINGS**

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 20, 2007 through April 24, 2007	Inpatient Hospital Services	\$78,223.28	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, effective May 2, 2006, sets out the definition of final action.
3. Former 28 Texas Administrative Code §133.305, 31 *Texas Register* 10314, amended effective January 15, 2007, sets out general provisions for medical dispute resolution.
4. Former 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. 28 Texas Administrative Code §134.1, effective May 2, 2006 31 *Texas Register* 3561, sets out the guidelines for fair and reasonable reimbursement.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 22, 2007

- SDAY-W1-Workers compensation state f/s adj. If reduction, then processed according to the Texas fee guidelines.
- INCD-97-Payment is included in the allowance for another service/procedure. Included in global reimbursement.
- DOP-W10-No maximum allowance defined by fee guideline. Reduced to fair & reasonable. No MAR been set by TWCC in the medical fee guideline.

Explanation of benefits dated July 27, 2007

- W1-Workers compensation state f/s adj. If reduction, then processed according to the Texas fee guidelines.
- 97-Payment is included in the allowance for another service/procedure. Included in global reimbursement.
- W10-No maximum allowance defined by fee guideline. Reduced to fair & reasonable. No MAR been set by TWCC in the medical fee guideline.

### **Issues**

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed \$40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

### **Findings**

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." On August 10, 2011, both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The Division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and

respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the Division will address whether the total audited charges ***in this case*** exceed \$40,000; whether the admission and disputed services in this case are unusually extensive; and whether the admission and disputed services in this case are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet those three factors.

1. 28 Texas Administrative Code §133.240(a) and (e), 31 Texas Register 3544, effective May 2, 2006, state, in pertinent part, that "(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill..." and "(e) The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division..." Furthermore, 28 Texas Administrative Code §133.2, 31 Texas Register 3544, states, in pertinent part "(4) Final action on a medical bill-- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or (B) denying a charge on the medical bill." The requestor asserts in its position statement that:

"The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges ... Title 28, TEX. ADMIN. CODE. §133.240(a)(e) specifically requires an insurance carrier to 'take final action on a medical bill no later than the 45<sup>th</sup> day after the date the insurance carrier received a complete medical bill.' 133.2 (4) Final action includes one or more of the following: (1) sending payment, (2) denying a charge on the medical bill; or (3) requesting reimbursement of an overpayment... The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)."

Review of the submitted documentation finds that the explanation of benefits dated June 22, 2007 and July 27, 2007 were issued using the division-approved form TWCC 62 and noted payment exception codes of "W1-Workers compensation state f/s adj. If reduction, then processed according to the Texas fee guidelines"; "97-Payment is included in the allowance for another service/procedure. Included in global reimbursement"; and "W10-No maximum allowance defined by fee guideline. Reduced to fair & reasonable. No MAR been set by TWCC in the medical fee guideline" for the services in dispute.

These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on the Per Diem provision in former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount, and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has substantially met the requirements of applicable §133.240, and §133.2.

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier on June 22, 2007 and July 27, 2007 finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$129,825.71. The Division concludes that the total audited charges exceed \$40,000.
3. The requestor in its original position statement asserts that "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below \$40,000, after the Carrier audits the bill pursuant to the applicable rules." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement dated October 28, 2011 the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to

whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

"The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive; and third, the median length of stay ("LOS") for workers' compensation inpatient admissions is three days whereas the length of stay for this admission exceeds the median LOS. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the Division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

"The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is \$23,187; the median charge for workers' compensation surgeries of this type is \$39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the \$40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries."

The requestor asserts that because the **billed charges** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the **costs** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed \$40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources

in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries, and therefore fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in "other types of surgeries." As noted above, the Third Court of Appeals' November 13, 2008 opinion stated that "...the Stop-Loss Exception was meant to apply on a case-by-case basis in a relatively few cases." The Division concludes that the requestor failed to demonstrate that the specific services in this dispute were unusually costly when compared to similar spinal surgery services or admissions.

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
  - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay is four days. The surgical per diem rate of \$1,118 multiplied by the length of stay of four days results in an allowable amount of \$4,472.00.
  - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
  - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at \$56,040.00. The respondent paid \$14,674.00.
  - The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
Cap Screw	4	\$395.00/each	$\$395.00 + \$39.50 =$ $\$434.50 \times 4 =$ $\$1,738.00$
Cage PLIF	2	\$2,895.00/each	$\$2,895.00 + \$289.50 =$ $\$3,184.50 \times 2 =$ $\$6,369.00$
Screw Pedicle	4	\$1,295.00/each	$\$1295.00 + \$129.50 =$ $\$1424.50 \times 4 =$ $\$5,698.00$
Rod 50mm	2	\$395.00 each	$\$395.00 + \$39.50 =$ $\$434.50 \times 2 = \$869.00$
TOTAL DUE	12		\$14,674.00

- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed \$346.60/unit for Thrombin USP TOP. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is \$19,146.00 (\$4,472.00 + \$14,674.00). The respondent issued payment in the amount of \$19,146.00 for the surgical days. Based upon the documentation submitted, no additional reimbursement can be recommended.

### **Conclusion**

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually costly services, and failed to demonstrate that the services in dispute were unusually extensive. The requestor further failed to establish that additional payment is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

### **Authorized Signature**

_____	_____	6/29/2012
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	6/29/2012
Signature	Medical Fee Dispute Resolution Manager	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**